COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH PROFESSIONS LICENSURE
239 CAUSEWAY STREET, SUITE 200
BOSTON, MA 02114
PHONE: 800-414-0168 • 617-973-0800
WEBSITE: www.mass.gov/dph/boards

BOARD OF REGISTRATION OF GENETIC COUNSELORS

APPLICATION FOR **FULL** LICENSURE

LICENSE APPLICATION - $ 300.00 **(NONREFUNDABLE)**

ALL QUESTIONS MUST BE ANSWERED

1. APPLICANT NAME: _____
Last First Middle

MAIDEN/OTHER NAME: _____
(if applicable) Last First Middle

2. ADDRESS OF RECORD: _____
Number Street Apt. Number

_____
City/Town State Zip Code

3. MOST RECENT PREVIOUS ADDRESS: _____
Number Street Apt. Number

_____
City/Town State Zip Code

4. TELEPHONE NUMBER(S) Day: _____ Evening: _____ Cell: _____

5. _____/_____/_____ _____ _____ EYE COLOR: _____
Date of Birth (mm/dd/yyyy) Place of Birth (city/state/country)

HEIGHT: ____ Feet ____ Inches WEIGHT: ____ Lbs. MOTHER'S MAIDEN NAME: _____

6. SOCIAL SECURITY NUMBER (SSN) (**disclosure is mandatory**): _____/_____/_____
Pursuant to G.L. c. 62C, s. 47A, the Division of Health Professions Licensure is required to obtain your SSN and forward it to the Massachusetts Department of Revenue. The Department of Revenue will use your SSN to ascertain whether or not you are in compliance with Massachusetts tax laws (G.L. c. 62C, s. 47A) and child support laws (G.L. c. 119A, s.16).

FOR BOARD USE ONLY

Application Number: _____ Receipt Number: _____

License Number _____ Provisional License Number: _____

EDUCATION

7. ABGC OR ABMG ACCREDITED DEGREE PROGRAM: _____
Program and Educational Institution

_____
Number Street City State Zip Code

Degree Awarded: _____ Date Degree Awarded:_____/_____/_____
(mm/dd/yyyy)

Applicant must arrange for an official transcript to be mailed directly to the Board by the degree-awarding institution.

8. UNDERGRADUATE EDUCATION: _____
Name of Institution

_____
Number Street City State Zip Code

Degree Awarded: _____ Date Degree Awarded:_____/_____/_____
(mm/dd/yyyy)

Applicant must arrange for an official transcript of undergraduate education to be mailed directly to the Board by the degree-awarding institution.

9. OTHER EDUCATION: _____
Name of Institution

_____
Number Street City State Zip Code

Degree Awarded: _____ Date Degree Awarded:_____/_____/_____
(mm/dd/yyyy)

Applicant must arrange for all official transcripts of other post-secondary education to be mailed directly to the Board by the degree-awarding institution.

CHECK ALL THAT APPLY

10. ☐ ABGC CERTIFICATE NUMBER _____ EXPIRATION DATE _____

☐ ABMG CERTIFICATE NUMBER: _____ EXPIRATION DATE: _____

Applicants must arrange for official verification of certification to be mailed directly to the Board by the ABGC or ABMG.

VERIFICATION OF OTHER LICENSES/ BOARD CERTIFICATIONS

11. LIST BELOW ALL OTHER PROFESSIONAL LICENSES AND BOARD CERTIFICATIONS HELD IN OTHER JURISDICTIONS:

☐ **I DO NOT CURRENTLY HOLD AND HAVE NEVER HELD A PROFESSIONAL LICENSE OR CERTIFICATION IN ANY STATE OR JURISDICTION.**

Issuing Jurisdiction	Profession	License/Certification Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Applicants must arrange for official documentation of current license status from each state or jurisdiction to be mailed directly to the Board.

QUESTIONS

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS PLEASE ATTACH A SEPARATE SHEET EXPLAINING THE CIRCUMSTANCES.

12. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

13. Has any licensing or certification board, government authority, hospital or health care facility or professional medical association located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?

Yes ☐ No ☐

14. Are you the subject of pending disciplinary actions by any licensing or certification board, government authority, hospital or health care facility or professional medical association located in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

15. Have you ever voluntarily surrendered any professional license or board certification in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

16. Have you ever been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor violations for which a fine of $100 or less was imposed.

Yes ☐ No ☐

RELEASE

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and genetic counseling associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Board of Registration of Genetic Counselors any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Registration of Genetic Counselors to release information contained in this application in association with its processing.

AFFIDAVIT OF APPLICANT

To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by state law and do not owe child support.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board for access to Criminal Offender Record Information (CORI), including conviction and pending criminal case data. As an applicant for a license to practice as a genetic counselor, I understand that a CORI check may be conducted by the Board for conviction and pending criminal case information only and that the CORI results will not necessarily disqualify me.

I understand that I am responsible for reading and understanding the laws and regulations governing practice as a licensed Genetic Counselor in Massachusetts and I hereby agree to comply with such laws and regulations.

I understand that this application for licensure as a Genetic Counselor shall be deemed no longer valid if requirements for full licensure as a Genetic Counselor are not met within one (1) year from the date of Board receipt. I also understand that fees are non-refundable and non-transferable.

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that any failure to provide truthful and accurate information in connection with this application for licensure may be grounds for the Board of Registration of Genetic Counselors to deny issuance of a license; to suspend or revoke a license issued to me; and to deny renewal of a license issued to me, all in accordance with Massachusetts law.

APPLICANT SIGNATURE _____ DATE _____

PRINT NAME _____

Attach a recent passport photo (2x2)

NOTARY NAME: _____

COMMISSION EXPIRES: _____ [Seal]

INCLUDE A NONREFUNDABLE FEE OF $300.00 (CHECK OR MONEY ORDER) PAYABLE TO THE COMMONWEALTH OF MASSACHUSETTS

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CORI REQUEST FORM

The Massachusetts Board of Registration of Genetic Counselors (Board) has been certified by the Criminal History Systems Board for access to Criminal Offender Record Information (CORI), including conviction and pending criminal case data. As an applicant to the Board for licensure as a genetic counselor, I understand that the Board may conduct a CORI check for authorized data using the information provided below and that any CORI check results will not necessarily disqualify me from licensure. I hereby attest that the information I have provided below is true and accurate to the best of my knowledge and belief.

_____ _____
LICENSE APPLICANT'S SIGNATURE DATE

_____
LAST NAME FIRST NAME MIDDLE NAME

_____ _____
MAIDEN NAME OR ALIAS (IF APPLICABLE) PLACE OF BIRTH (CITY, TOWN, COUNTRY)

_____ _____ _____
DATE OF BIRTH (DD/MM/YYYY) SOCIAL SECURITY NUMBER **(REQUESTED BUT NOT REQUIRED)** ID THEFT INDEX PIN **(IF APPLICABLE)**

_____
MOTHER'S MAIDEN NAME

CURRENT AND FORMER ADDRESSES: _____

_____

SEX: ____ HEIGHT: _____ WEIGHT: _____ EYE COLOR: _____ STATE DRIVER'S LICENSE_____

FOR OFFICIAL USE ONLY
CORI REQUESTED BY: _____ _____
SIGNATURE OF CORI AUTHORIZED EMPLOYEE PRINT NAME